Infinite Options Counseling

Client Intake Form

The information requested on this form will be kept confidential and will help your counselor to assist you. Please fill out the form as completely as you can.

Problem Definition

What is the reason for seeking help now?

_____

_____

_____

Are any of the following conditions a problem to you (or your child if they are the client) at this time?

- ☐ Anxiety
- ☐ Grief
- ☐ Depression
- ☐ Irrational Fears
- ☐ Stress
- ☐ Frequent Worry
- ☐ Loneliness
- ☐ Anger
- ☐ Loss of work/job
- ☐ Poor Concentration
- ☐ Racing thoughts
- ☐ Difficulty Sleeping
- ☐ Nightmares
- ☐ Loss of Interest
- ☐ Flashbacks
- ☐ Lethargy
- ☐ Self Esteem
- ☐ Suicidal Feelings
- ☐ Rage
- ☐ Sexual Issues
- ☐ Coping with Divorce
- ☐ Domestic Violence
- ☐ Self Injury Behaviors
- ☐ School Problems
- ☐ Financial Stress
- ☐ Hyperactivity
- ☐ Codependency
- ☐ Too Much Energy
- ☐ Loss of Appetite
- ☐ Substance use/abuse
- ☐ Loss of Hope
- ☐ Partner Relationship Problems
- ☐ Parenting Issues
- ☐ Mood Instability
- ☐ Abuse or Trauma
- ☐ Issues with Eating
- ☐ Work Problems
- ☐ Impulse Control
- ☐ Loss of Meaning in Life

What would you like to see happen as a result of counseling?

_____

_____

Make a check if any of these statements are true:

☐ **I have had thoughts of harming myself or someone else**

☐ **My thought of harming myself or someone else are frequent**

☐ **I am sometimes afraid I cannot control my thoughts of hurting myself or someone else**

☐ **I have sought help in the past due to thought of hurting myself or someone else**

Medical History

Please list any medical conditions you have been treated for (past or present)

_____

_____

Please list any medications you currently use, dose and frequency. If none please check
☐ **NONE**

_____

_____

Date of your last physical exam: _____

Do you have any known drug, food, or other allergies?

☐ **No**

☐ **Yes, specify:**_____